Voluntary MEDICAL and HOSPITAL INSURANCE in Canada

RESEARCH DIVISION
General Series No. 9
DEPARTMENT OF NATIONAL HEALTH AND WELFARE
Ottawa
August 1955

VOLUNTARY MEDICAL AND HOSPITAL INSURANCE IN CANADA

General Series, Memorandum No. 9

Published by the Authority of the Hon. Paul Martin
Minister of National Health and Welfare

Research Division
Department of National Health and Welfare
Ottawa, August 1955

FOREWORD

This is the second bulletin which the Research Division of the Department of National Health and Welfare has prepared dealing with voluntary insurance in the health care field. An earlier bulletin (Memorandum Number 4, General Series) entitled "Voluntary Medical Care Insurance: a study of non-profit plans in Canada" analyzed a variety of factors relating to the operations of fourteen non-profit medical care insurance plans.

While this new volume offers a less detailed discussion of non-profit medical care programs, it discusses these plans on a province-wide basis. In addition, the scope of the study is broader in that it covers hospital as well as medical care insurance and private insurance plans as well as non-profit plans. While it has not been possible to include all types of plans sponsored by a variety of organizations, it is believed that the plans discussed in this document are those which cover a large majority of the insured population.

The Joint Committee on Health Insurance, representing private insurance companies, has kindly made available information about their operations which has been included for the first time in this series of bulletins. Some statistics from the annual reports of several Blue Cross

Plans have also been used. The various non-profit medical plans under the sponsorship of the medical profession, or operated by non-profit corporations, co-operatives and so on, have continued to assist us in the conduct of these studies and have made a number of helpful suggestions.

This bulletin should be read along with Memorandum Number 15, Social Security Series, entitled "Selected Public Hospital and Medical Care Plans in Canada", in order to obtain a complete nation-wide picture of the extent of public and private insurance against the costs of illness. It has been prepared in the Health Care Studies Section by Mr. John E. Osborne, under the supervision of John E. Sparks and C. Lloyd Francis.

Joseph W. Willard

Joseph W. Willard,
Director, Research and Statistics Division.

August, 1955.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF CHARTS

CHAPTER I - INTRODUCTION

The growing interest of the Canadian consumer in seeking assistance to meet one of the major contingencies threatening family security is indicated by the rapid expansion in enrollment under voluntary health care insurance programs in the last few years, and the increased proportion of the nation's health care dollar which is met by these programs. It is estimated that, at the end of 1953, about 4.6 million persons or 30 per cent of the total Canadian population(1) had purchased insurance for some type of medical care benefits, (i.e. physicians' services), after allowing for duplication, as compared with 1.2 million persons or 10 per cent of the population at the end of 1948. Similarly, coverage under voluntary hospital care programs increased from about 3.5 million persons or 27 per cent of the total population in December 1948 to 5.9 million persons or 40 per cent of the population in December 1953. In the six provinces without public hospital care programs, the voluntary plans had enrolled 5.5 million persons, or almost 50 per cent of the 1953 population of those provinces. It would appear that about 25 per cent of total payments to physicians and

---

(1) The "total Canadian population" of 14,964,000 in December 1953 used throughout this chapter excludes the Northwest Territories but has not been adjusted to exclude persons in institutions or the armed services, Indians, or persons obtaining health care services as indigents or public assistance recipients.

24 per cent of our total public and private general hospital care bill were provided through these voluntary programs in 1953,[1] as compared with an estimated 11.5 per cent and 18.5 per cent respectively in 1950.[2]

At the present time there are seventeen major non-profit health care insurance plans in Canada, of which fifteen offer medical care benefits to their members, and eight offer hospital care benefits. Nine of these plans are sponsored directly by the medical associations of the regions in which they operate, and two by the hospital associations. Two of the plans are of the consumer co-operative type, and the remainder are private corporations with medical, hospital, and lay representatives on their governing boards.

In addition to these plans, at least 60 of the private insurance companies operating in Canada offer group or individual contracts designed to indemnify or reimburse a policy-holder up to stated maximum amounts for hospital, surgical and medical bills. There are also a number of other co-operative, fraternal, union and industrial programs which provide their members (or employees) with some measure of hospital or medical care benefits.

---

(1) See Research Division, Health Care in Canada: Expenditures and Sources of Revenue, 1953, Memo. No. 12, General Series, (Ottawa: D.N.H. & W., 1955).

(2) It should be pointed out, however, that these percentages may be over-estimated to some extent, since they are based on the assumption that physicians or hospitals received all the payments of benefits made under insurance programs. In fact, persons who are doubly insured may receive indemnification payments larger than their total health care bills.

CHAPTER II - MEDICAL CARE INSURANCE

COVERAGE AND BENEFITS

(1) Non-Profit Plans

In describing the benefits that are available to insured persons under non-profit medical care insurance contracts, it is helpful to classify the contracts as either "comprehensive" or "limited", according to the range of benefits offered. A "comprehensive" contract is here defined as one which provides a wide range of benefits, including payments for physicians' calls in office, home and hospital, consultations, surgical operations and procedures, anaesthesia, confinements, and x-ray, laboratory and other diagnostic procedures. A "limited" contract on the other hand provides only a limited selection of these benefits, such as surgical and obstetrical care, with or without medical (non-surgical) care in hospital.

Another method of classifying the medical care insurance programs is according to the way in which they pay for the benefits received by their members. "Indemnification" contracts, which are the most numerous kind, guarantee to reimburse the individual member for some of his medical care expenses up to certain fixed maximum sums for each type of service purchased.(1) Charges beyond these maxima are the responsibility of the member. "Service" plans, on the other

---

(1) A distinction is made by the private insurance companies between "indemnification" and "reimbursement" contracts, see p. 8.

hand, enter into contracts with participating physicians on behalf of their members. Under the only "full service" plan in Canada, (Manitoba Medical Service), physicians agree to accept the fees paid by the plan as full payment for services rendered. The eight "partial service" plans guarantee to pay the full cost of general practitioner care rendered to their members by doctors under contract, but unlike the full service plan, they permit certified specialists to charge additional fees for their services if they so wish.(1) In addition, most of the service plans limit their total annual expenditures for each member on certain diagnostic and laboratory procedures.

By the end of 1958 nine of the non-profit plans had enrolled 1.1 million persons, or 7.5 per cent of the total population, for "comprehensive" medical care benefits, and ten of the plans had enrolled 1.22 million persons (8.2 per cent) for "limited" benefits. These figures indicate a considerable growth of the plans since December, 1949, when only 410,000 persons (3.0 per cent) were covered for comprehensive and 480,000 persons (3.5 per cent) for limited benefits.

The percentage increase in enrollment over the previous year under these non-profit plans for the period

---

(1) Referred specialist services are usually paid in full by the plan in B.C., while the Windsor Medical and SSQ plans pay 100 per cent and 50 per cent, respectively, of the cost of specialist care for their lower-income members. The plan in Regina pays for some specialist services in full, and sets a maximum limit on the extra-billing for other items.

1946-1953 is shown in Table 1. The large increase in enrollment under limited contracts in 1947 was due largely to the introduction of a surgical-medical care contract by Quebec Hospital Service Association in that year. Similarly, the increase in comprehensive enrollment in 1950 was accounted for mainly by the expansion of Physicians' Services Incorporated (Ontario) over its 1949 membership. In the period, 1947 to 1953, the trend for all contracts, including both comprehensive and limited contracts, has been towards a slowly declining annual rate of growth of enrollment. This is, of course, understandable, since a higher percentage of the eligible population is being covered each year. The population itself has been expanding over this period at a rate of about 3 per cent a year.

Table 1. PERCENTAGE INCREASE IN ENROLLMENT OVER PREVIOUS YEAR UNDER NON-PROFIT COMPREHENSIVE AND LIMITED MEDICAL CARE CONTRACTS 1946 TO 1953

	1946	1947	1948	1949	1950	1951	1952	1953
Comprehensive	54	54	40	24	37	31	27	19
Limited	66	1275	67	59	42	23	22	19
All contracts	55	150	52	41	40	27	24	19

Source: Tables 3 and 8 (revised) of Voluntary Medical Care Insurance: a study of non-profit plans in Canada, General Series Memorandum No. 4, Research Division, D.N.H.&W. 1954.

If the enrollment under non-profit plans is considered in terms of "service" and "indemnification" programs, it will be found that of the fourteen major non-profit medical care plans operating in Canada in December 1953, the one "full service" plan covered 171,000 persons, the eight "partial service" plans covered over one million persons, and five "indemnification" plans had enrolled 1.1 million persons. These enrollment figures may be contrasted with the corresponding figures for 1949, which were 88,000, 345,000 and 456,000 persons, respectively. Thus, the total enrollment among the non-profit plans increased from 889,000 persons in 1949 to 2,320,000 in 1953.

No more than 21 per cent of the total population of any province was covered in 1953 for any type of medical care benefits under these non-profit plans. As may be noted from Table 2, the proportion of provincial populations enrolled with these plans ranged from about 2 per cent in Newfoundland[1] to about 21 per cent in Manitoba. Private insurance company coverage, for both surgical and medical insurance, was least extensive in Saskatchewan and most extensive in Ontario. These proportions are presented graphically in Chart 1.

---

(1) About one-third of Newfoundland's population are covered for medical benefits under the provincial Cottage Hospital Plan.

Table 2. NUMBER OF PERSONS AND PERCENTAGE OF POPULATION COVERED FOR MEDICAL CARE INSURANCE(a) UNDER NON-PROFIT PLANS AND PRIVATE INSURANCE COMPANIES, BY PROVINCE, DECEMBER 1953

Province	Non-Profit Plans		Private Insurance Companies(b)			
			Surgical Contracts		Medical Contracts	
	Total Enrollment	Per Cent of Population	Total Enrollment	Per Cent of Population	Total Enrollment	Per Cent of Population
Newfoundland	7,508	1.9	21,400	5.5	20,700	5.3
Prince Edward Island	10,212	9.7	4,200	4.0	3,400	3.2
Nova Scotia	83,833	12.6	42,500	6.4	29,400	4.4
New Brunswick	112,153	20.7	36,300	6.7	25,900	4.8
Quebec	637,977	14.7	792,300	18.3	474,400	11.0
Ontario	890,084	17.9	1,326,800	26.7	678,100	13.6
Manitoba	171,011	20.9	74,100	9.0	35,100	4.3
Saskatchewan	119,298	13.7	31,000	3.6	18,200	2.1
Alberta	58,827	5.8	160,900	15.8	78,000	7.6
British Columbia	228,685	18.3	103,000	8.3	60,500	4.8
Canada(c)	2,319,588	15.5	2,592,500	17.3	1,423,700	9.5

(a) The figures in this table cannot be added horizonally, since most persons with private insurance medical contracts are included in the figures for those holding surgical contracts, and since adjustments have not been made to allow for persons who are insured under both non-profit and private insurance programs.

(b) No allowance made for duplication of coverage under group and individual contracts.

(c) Excluding Yukon and N.W.T.

Source: Data provided by each of the non-profit plans, and by the Joint Committee on Health Insurance, representing the insurance companies.

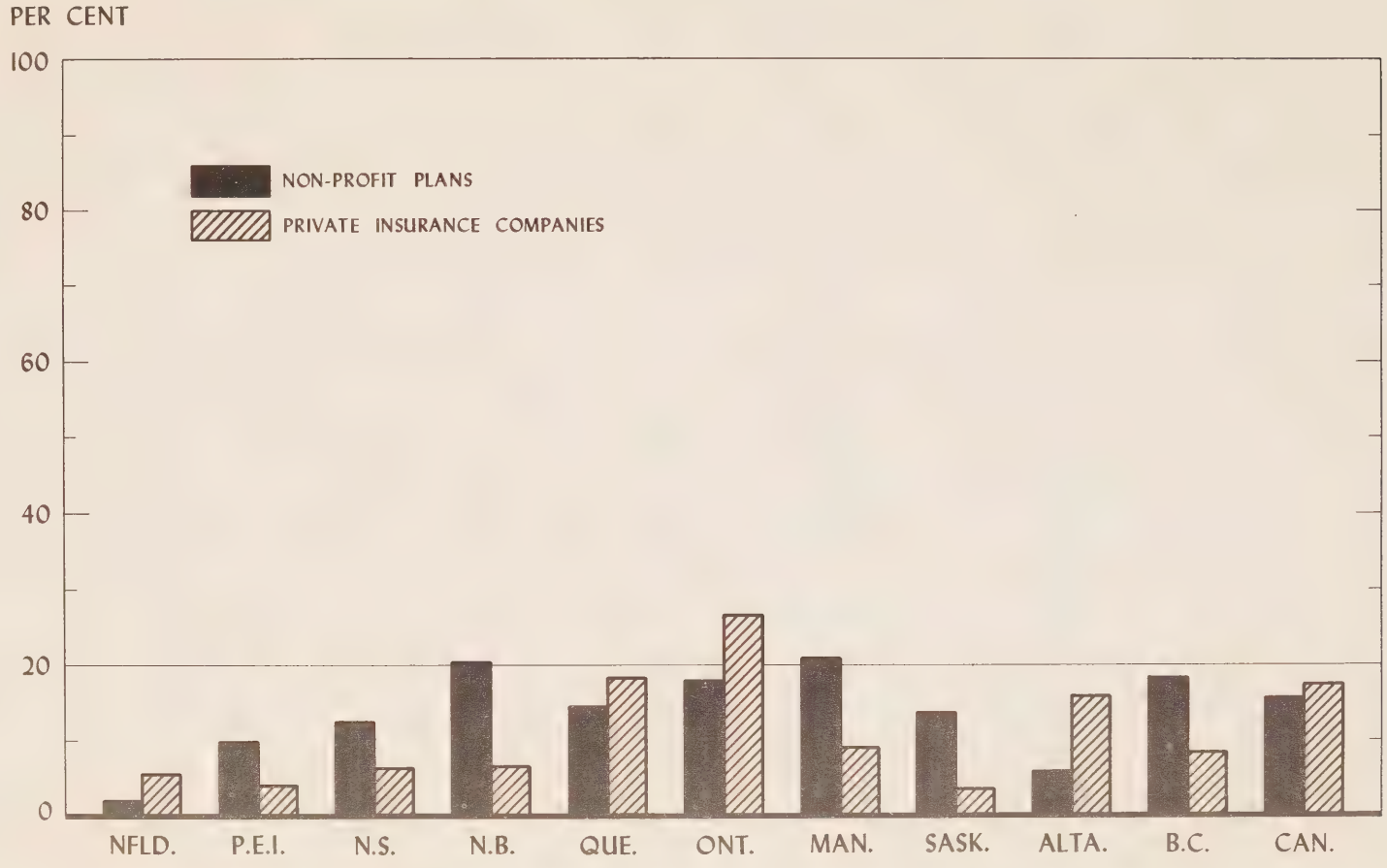
(2) Private Insurance Company Plans

In the last few years there has been a very rapid expansion in the number of persons insured for medical care benefits with the private insurance companies. Contracts covering 2.6 million persons for surgical benefits or almost 18 per cent of the total Canadian population, were in force at the end of 1953, as shown in Table 2. In the same year contracts covering 1.4 million persons, or nearly 10 per cent of total population, entitling them to medical (non-surgical) benefits, had been issued by these companies. It should be noted that most people holding medical care contracts are also insured for surgical benefits, and that therefore most of the 1.4 million are included amongst the 2.6 million persons so insured.

Classification of the private insurance company contracts requires a somewhat different approach than the service-indemnification distinction applied to non-profit contracts. The insurance companies, which do not offer "service" contracts as defined above, differentiate between "reimbursement" and "indemnity" contracts. A "reimbursement" contract is one that is designed to reimburse the patient, within specified limits, for the actual charges for which he is liable. He will not be paid more than the maximum rates stipulated in his contract, nor will he be paid more than the actual amount of the physician's (or hospital) bill which he has incurred. An "indemnity" contract, on the other hand,

CHART I

PERCENTAGES OF TOTAL POPULATION ENROLLED FOR MEDICAL CARE BENEFITS, UNDER NON-PROFIT PLANS AND PRIVATE INSURANCE COMPANIES, BY PROVINCE, DECEMBER 1953[a]



[a]Percentages should not be added, since no allowance has been made for duplication of coverage

Source: Table 2

guarantees to pay the patient a fixed sum of money, without regard to the actual charges for which he is liable. On the basis of the distinction made by the insurance companies, the indemnification contracts offered by five non-profit plans would be classed as "reimbursement" contracts.(1) The great majority of the private insurance company contracts are of the reimbursement type, which, of course, do not meet the full cost of a patient's surgical and medical bills if these are greater than the maximum rates specified in the contract for each item of service.

Among the companies which underwrite the costs of medical and surgical care, four general types of contract are provided. The insured patient may be reimbursed under a medical expense contract, up to a stated maximum rate for each visit, for the costs to him of (a) physicians' attendances in the home, office, and hospital, (b) physicians' attendances while the wage-earner is disabled (i.e. absent from employment because of illness), or (c) physicians' attendances in hospitalized cases, excluding post-operative surgical calls. In each of these three types of contract, a maximum limit is usually set to the total benefits payable during any one period of disability, and it is not uncommon that the first one or two calls must be paid for by the patient. The fourth type of contract covers surgical care, and sets forth in an accompanying schedule the maximum sums

---

(1) See p. 3.

payable for each type of surgical operation. In addition to these contracts, a supplementary "diagnostic benefit" may be purchased, under a few policies, to assist in meeting the cost of laboratory and x-ray diagnostic services received by non-hospitalized insured patients. In recent years a new type of contract has been developed to cover "major medical expenses" over and above those normally covered under the ordinary medical and hospital contracts offered by these companies. These contracts are usually only sold to persons already covered for "ordinary" medical and hospital benefits, and require the patient to meet the first $100, $200 or $500 (or a fixed percentage of his income) over and above any basic benefits payable under his other contracts. The insurance companies will reimburse the patient to the extent of about 75 per cent of his expenditures on medical, hospital and nursing care and prescribed drugs beyond these "deductible" amounts for which the patient is responsible. In addition to these deductible and "co-insurance" features, such contracts usually set some maximum amount that will be paid for any one illness or disability.

Although detailed information is not at present available concerning the enrollment under each of these types of contract, it is possible to show coverage under group contracts and individual policies separately. At the end of 1953, group contracts had been issued covering 2.15 million persons for surgical benefits, and 1.3 million for medical (non-surgical) benefits. Individual policies were not nearly

so numerous, since they covered only 438,000 persons for surgical benefits and 137,000 persons for medical (non-surgical) benefits in the same year. A total, therefore, of about 2.6 million persons were insured for surgical benefits in 1953, and 1.4 million for medical benefits, with the private insurance companies, with no allowance for any duplication between group and individual policy enrollment figures (i.e. for persons holding both types of policy). These figures represent a considerable expansion over the three year period since 1950 (the first year for which these statistics were collected) from an estimated 1.6 million and 660,000 persons insured for surgical and for medical benefits, respectively.

However, despite this very considerable growth in the coverage of the private insurance companies, there has been a relative decline in their annual rates of growth. As Table 3 indicates, the growth of the group contracts has been slowing down since 1951: whereas coverage under surgical contracts increased by 35 per cent in 1951, this growth fell to 15 per cent in 1952 and to 12 per cent in 1953. Similarly the medical contracts, which had expanded their coverage by 52 per cent in 1950, increased by 37 per cent in 1952 and by only 18 per cent in 1953. Although accurate figures for the numbers covered under individual contracts are not available for each of these years, there has apparently been a similar trend in the annual rates of growth of coverage under these contracts.

Table 3. PERCENTAGE INCREASE IN COVERAGE OVER PREVIOUS YEAR UNDER PRIVATE INSURANCE COMPANY GROUP AND INDIVIDUAL CONTRACTS FOR SURGICAL AND MEDICAL CARE BENEFITS, 1951 TO 1953

	1951	1952	1953
Surgical - Group	34.5	15.3	11.8
Individual	not available		4.3
Medical - Group	52.1	36.8	17.6
Individual	not available		-18.9(a)

(a) Decrease largely due to the withdrawal of one large company from this field of insurance.

Source: Financing Health Services in Canada, (Joint Committee on Health Insurance, Toronto, 1954), Appendix A, p. 19 and Supplement 1955.

With regard to the comprehensiveness of the range of benefits offered under private insurance company medical expense contracts, a recent survey of six companies, which in 1952 insured 46 per cent of all persons holding such medical expense contracts, indicated that about two-thirds of their group medical expense policyholders had chosen contracts which included home and office calls among the benefits for which payment would be made, as well as hospital calls. The extent to which the remaining 54 per cent of the medically-insured have chosen "home and office" contracts is not at present available.

(3) Total Coverage

In summary, a total of 4.6 million persons, or 30 per cent of the total Canadian population, were covered under the

voluntary plans for some type of medical or surgical care benefits at the end of 1953. This figure includes 2.3 million persons enrolled with the non-profit medical care plans, and about 2.6 million persons insured with private insurance companies, with an allowance of 342,000 for duplication in enrollment under both group and individual contracts, and with both non-profit plans and private insurance companies.(1)

SPECIAL ASPECTS OF INSURANCE COVERAGE

In describing the efforts of the voluntary plans to extend their benefits to the Canadian population, it should be borne in mind that more people are currently insured under contracts covering groups of employees than under policies issued to individuals as such. About 80 per cent of persons enrolled with the non-profit plans are covered under employee group contracts. A few of these plans also enroll community groups, service clubs, or credit union members, but only four plans offer individual contracts, and these cover only about 5 per cent of the enrolled population. Similarly, although at least 45 private insurance companies write individual policies, the activities of the insurance industry are mainly directed towards enrolling employee

(1) Estimates of duplication have been obtained from Financing Health Services in Canada, (Joint Committee on Health Insurance, Toronto, 1954) Appendix A. pp. 19 and 23, and Supplement, 1955.

groups. Over 83 per cent of persons covered under their surgical policies and over 90 per cent of those covered under their medical policies in 1953 were insured under group policies.

Because of this "employee group" feature, only six of the fourteen non-profit plans operating in 1953 imposed a maximum age limit on new membership, a limit which varied from 55 to 70 years. None of the Canadian non-profit plans impose any maximum income limits on membership. However, two of these plans do specify that members receiving over a certain income may obtain benefits only on an indemnification and not a service basis - that is, they may be called upon to pay additional fees to the general practitioner as well as to the specialist. It has already been mentioned that regardless of income levels, such "extra-billing" is permitted, either with or without limitations, under all but one of the non-profit plans with regard to specialist services, but not for general practitioner care.(1)

The benefits available to members of non-profit plans are sometimes subject to a waiting-period of a few months after enrollment before eligibility commences. This is particularly true of confinements, and often applies to specified surgical operations as well. However, pre-existing conditions may be treated immediately under several of the comprehensive contracts (covering two-thirds of those

(1) See p. 4 n. 1.

enrolled for comprehensive benefits), although the limited contracts usually impose a twelve month waiting period for such treatment. Treatment for pre-existing conditions is usually excluded from the benefits available to persons enrolled on an individual basis.(1)

VOLUME OF SERVICE

No data are at present available regarding the volume of medical care benefits received by persons insured with the private insurance companies. However, information on the volume of services rendered to enrolled persons in 1953 has been made available by two of the non-profit comprehensive plans. Although the overall utilization rates have increased somewhat since 1951(2) the proportionate distribution among the various items of service has not changed significantly.

In the two reporting plans, total services rendered amounted to 3.8 and 4.4 services per capita in 1953, including 3.0 and 3.5 physicians' calls per person, as indicated in Table 4. Total office calls amounted to 1785 and 2146 per thousand persons under Plans A and B respectively, while the home call rate was reversed at 612 and 538 per thousand respectively.

---

(1) Under Maritime Hospital Service Association, for example, certain chronic recurrent conditions may be "ridered" for a period, or for life.

(2) See Voluntary Medical Care Insurance: a study of non-profit plans in Canada, Chapter IV, for earlier data.

Table 4. NUMBER OF MEDICAL SERVICES RENDERED PER THOUSAND MEMBERS PER YEAR, AND PER CAPITA PAYMENTS TO PHYSICIANS,(c) BY TYPE OF SERVICE, TWO COMPREHENSIVE NON-PROFIT PLANS, 1953.

Type of Service	Plan A		Plan B	
	Volume of Services Per 1,000	Payments Per Capita	Volume of Services Per 1,000	Payments Per Capita
		$		$
Physicians' Calls				
Office	1785.4	4.37	2146.3	4.82
Home (incl. extra patient)	611.8	1.92	538.3	1.62
Night	52.9	.22	39.0	.17
Hospital	448.6	.73	373.3	.74
Consultations	62.4	.57	34.3	.26
Pre. & Post Natal	65.0	.17	217.6	.44
Annual Medicals	(a)	(a)	17.8	.08
Total	3026.1	7.98	3467.6	8.13
Surgery				
Tonsillectomies	18.5	.45	22.9	.55
Appendectomies	6.0	.55	5.8	.52
Other Major	29.1	2.67	32.5	2.89
Other Minor	98.6	1.04	104.6	.75
Total	152.2	4.71	165.8	4.71

Table 4. - Continued

Anaesthetist	70.9	.88	78.6	.98
Fractures	11.2	.35	11.8	.37
Confinements	19.2	1.02	27.0	1.03
Diagnostic Services				
x-rays (diagnostic)	97.3	1.07	104.6	1.00
x-rays (therapeutic)	28.6	.11	(a)	(a)
E.K.G.'s	12.1	.11	13.5	.15
B.M.R.'s	3.4	.02	8.5	.04
Cystoscopies	(b)	(b)	5.5	.11
Total	141.4	1.31	132.1	1.30
Miscellaneous				
Injections	205.4	.19	328.7	.32
Refractions	46.7	.26	53.6	.26
Other	103.2	.50	113.0	.50
Total	355.3	.95	495.3	1.08
Total All Services	3776.2	17.20	4378.2	17.60

(a) Not provided.

(b) Included in other miscellaneous.

(c) These figures represent actual payments to physicians, and not necessarily the full amount of allowed claims for medical services received by the members.

Source: Adapted from statistics provided by the plans concerned.

It is interesting that the rates for surgical operations and procedures under the two plans are quite similar, totalling 152 services per thousand in Plan A and 166 per thousand in Plan B, and consisting largely of minor surgery. Diagnostic services accounted for 141 and 132 services per thousand under these two plans with Plan B, in addition to having a higher physician call rate, paying for more diagnostic x-rays, and more BMR's per thousand than Plan A.

In each case, the 1953 rates indicate an increased demand for services over the experience of previous years. In Plan A, the total volume of services increased from 2937 per thousand in 1949 and 3417 in 1951 to 3776 in 1953, including rates for physicians' calls of 2375, 2787 and 3026 per thousand in these years respectively. Plan B, an older plan, with a smaller rate of growth, experienced higher but more stable rates over this period, with total services increasing from 4200 per thousand in 1949 and 4151 in 1951 to 4378 in 1953, and physicians' calls amounting to 3234, 3229 and 3468 per thousand, respectively.

Windsor Medical Services Inc., is the only plan which has published up-to-date figures on its morbidity rate - that is, the percentage of members receiving medical attention each month. The rate for its comprehensive contract has been roughly 1 in 5 (or 19 per cent) over the last five years.

FINANCIAL EXPERIENCE

Another indication of the growth of the voluntary medical care insurance plans since 1949 is the increase in expenditures on benefits over this period. Total expenditure on benefits in 1953 amounted to about $42 million, of which $27 million was spent by the non-profit plans,(1) and $15 million by the private insurance companies. This expenditure represents a very considerable increase over the estimated total figure for 1950 of $16 million.

(1) Non-profit plans

Among the non-profit plans above, payments to physicians for medical care provided to members of these plans increased from $8 million in 1949 to $27 million in 1953, as shown in Table 5, or from $10.35 to $12.60 per insured person. When analyzed by province, it will be noted that 37 per cent of the 1953 total was spent in Ontario, 18 and 17 per cent in British Columbia and Quebec, and 11 per cent in Manitoba. On a per member basis, however, the plans in British Columbia and Manitoba ranked highest, spending on benefits $23.70 and $19.85 per member respectively, while those in Quebec and Newfoundland ranked lowest at $7.25 and $5.10 per member.(2) The payments per member in

(1) This sum consists of actual payments to physicians, and does not represent the full value of allowed claims for medical services received by members.

(2) Differences in benefits available under the different plans should be considered however, in such comparisons.

Table 5. AVERAGE NUMBER OF PERSONS COVERED FOR MEDICAL CARE BENEFITS UNDER FOURTEEN NON-PROFIT PLANS, AND TOTAL AND PER CAPITA EXPENDITURES(a) ON BENEFITS, BY PROVINCE, 1949 AND 1953

Province	1949(b)			1953		
	Average No. of Persons Covered	Benefit Expenditures		Average No. of Persons Covered	Benefit Expenditures(c)	
		Total	Per Capita		Total	Per Capita
		$	$		$	$
Newfoundland(d)	1,200	7,900	6.50	7,500	38,000	5.10
P.E.I.(d)	2,800	18,400	6.50	10,200	80,000	7.80
Nova Scotia(d)	15,000	122,000	8.15	82,900	957,000	11.50
New Brunswick(d)	28,000	184,000	6.50	112,200	863,000	7.70
Quebec	322,400	2,091,000	6.50	638,100	4,629,000	7.25
Ontario	169,000	2,187,000	12.95	771,500	10,004,000	13.00
Manitoba	56,700	678,000	11.95	155,900	3,092,000	19.85
Saskatchewan	20,400	235,000	11.55	107,300	1,606,000	15.00
Alberta	17,500	188,000	10.75	56,000	877,000	15.65
British Columbia	129,900	2,178,000	16.75	206,400	4,891,000	23.70
Total Ten Provinces	762,900	7,889,000	10.35	2,148,000	27,037,000	12.60

(See next page for footnotes.)

(a) The amounts used in this table as total benefit expenditures represent actual payments to physicians, and not necessarily the full value of allowed claims for medical services received by the members.

(b) Twelve plans only.

(c) See Appendix I

(d) Estimates, subject to revision.

Source: Voluntary Medical Care Insurance: a study of non-profit plans in Canada, (Ottawa: Dept. National Health and Welfare, 1954) Appendix IV, and additional material provided by some of the plans.

Newfoundland actually decreased between 1949 and 1953, while those in Ontario remained almost constant.(1) With these exceptions, per member payments in all the other provinces increased over this period, due either to increased fees for medical services, or to increases in the average volume of services received per member (utilization rate), or both, with the largest increase from $11.95 to $19.85 (66 per cent), occurring in Manitoba, which has the only "full service" plan in Canada.

(a) Comprehensive contracts -

However, the 1953 figure of $12.60 per capita obscures the fact that the average per capita expenditure for comprehensive benefits in that year was $18.70, as indicated in Table 6, and for limited benefits was only $7.20. The corresponding figures in 1949 were $14.60 and $6.20.(2) Of the $19 million spent by the plans on comprehensive benefits in 1953, over $7 million was paid out by the Ontario plans, and almost $5 million in British Columbia, or $17.60 and $23.70 respectively per capita. The plan in Manitoba experienced the second highest per capita expenditures for comprehensive benefits in that year, slightly over $21.00 per member. This represents a considerable increase from an

---

(1) But see Table 6.

(2) Figures relating to 1949 expenditure used in this section have been taken from Voluntary Medical Care Insurance: A study of non-profit plans in Canada, Research Division, (D.N.H.&W. Ottawa, 1954), Table 15.

estimated $12.70 per capita in 1949, resulting largely from higher utilization rates among the members. The schedule of fees used by the plan in Manitoba is unique in that it sets forth different rates for general practitioners and specialists, and permits no extra-billing of the patient.(1) The expenditure per member in Ontario rose from $14.35 in 1949 to $17.60 in 1953, the third highest in Canada, due almost solely to increases in the average cost per service and only slightly to increased utilization rates.

(b) Limited contracts -

Of the $8 million spent in 1953 on limited medical benefits, over half was spent in Quebec, and almost one-third in Ontario, at rates of $7.10 and $7.35 per member respectively. The corresponding rates in 1949 were $6.50 and $6.25, respectively, indicating considerably smaller increases over this period than were experienced under the comprehensive contracts. This difference is easily understandable when it is recalled that, for the most part, the limited benefit contracts are offered by "indemnification" plans whose expenditures are not necessarily affected by increases in provincial medical fee schedules.

---

(1) The plan in Regina includes in its fee schedule specialist rates for particular procedures considered to be beyond the scope of a general practitioner. For other services, specialists are paid at g.p. rates, and may extra-bill only up to the amounts set forth in the contract fee schedule as the specialist rates for such services.

Table 6. VOLUNTARY INSURANCE EXPENDITURES ON MEDICAL CARE BENEFITS, BY TYPE OF BENEFIT, NON-PROFIT AND PRIVATE COMPANY PLANS, BY PROVINCES, 1953

Province	Non-Profit Plans				Private Insurance Companies			
	Comprehensive Benefits		Limited Benefits		Surgical Benefits		Medical Benefits	
	Total	Per Capita	Total	Per Capita	Total	Per Capita	Total	Per Capita
	$	$	$	$	$	$	$	$
Newfoundland	-	-	38,505	5.13	104,000	5.59	46,000	2.80
P.E.I.	-	-	79,549	7.79	21,000	5.53	8,000	2.50
Nova Scotia	767,000	14.85	190,223	6.06	206,000	5.24	66,000	2.50
New Brunswick	-	-	862,633	7.69	172,000	5.21	58,000	2.49
Quebec	420,510	13.56	4,310,030	7.10	3,697,000	5.10	1,058,000	2.38
Ontario	7,425,522	17.60	2,578,028	7.36	6,258,000	4.77	1,529,000	2.34
Manitoba	3,031,508	21.07	60,956	5.06	340,000	4.91	79,000	2.48
Saskatchewan	1,605,952	14.97	-	-	149,000	5.32	40,000	2.40
Alberta	877,295	15.67	-	-	745,000	4.96	176,000	2.38
British Columbia	4,891,191	23.70	-	-	462,000	5.06	140,000	2.63
CANADA(a)	19,018,978	18.69	8,119,924	7.18	12,154,000	4.92	3,200,000	2.38

(a) Excluding Yukon and Northwest Territories.

Source: Statistics provided by the non-profit plans concerned, and by the Joint Committee on Health Insurance, Toronto.

(c) Administration -

In order to administer their medical benefit programs, the fourteen non-profit plans spent about $2.7 million in 1953, or just 10 per cent of the amount they spent on benefits and 8.7 per cent of their premium collections. Expenditures on administration in each province varied from a low of 5.5 per cent of income in British Columbia to a high of about 15 per cent in Newfoundland and New Brunswick, with the plans in Manitoba and Ontario spending 8.7 per cent of income, the average for all Canada.(1)

(2) Private Insurance Company Plans

For the private insurance companies less detailed information is available. However, it will be noted from Table 6 that a total of $15.4 million was paid out in 1953 by these companies for surgical and medical benefits. These payments were almost three times the amounts paid out under such policies in 1950, indicating the very rapid expansion in this type of insurance. Over $12 million was spent on surgical benefits alone in 1953, of which over half was paid on behalf of Ontario policyholders and almost one-third for insured persons in Quebec. On a per capita basis, however, there was not much variation among the provinces from the average of $4.92 per insured person.(2) The same pattern is

---

(1) See Appendix I

(2) Duplication as between persons covered under both group and individual contracts has been disregarded in calculating this per capita figure.

found among the medical benefit contracts on which these companies spent $3.2 million, or $2.38 per insured person. It should be pointed out that the surgical and medical benefits paid by the insurance companies must be considered in combination if they are to be compared with the benefits provided by the non-profit plans.

PROBLEMS OF EXTENDING VOLUNTARY INSURANCE

Among the special problems which affect the operations of the non-profit plans are the extension of coverage to a larger portion of the population, and the provision of continuity of coverage for persons moving from one province to another. The private insurance company plans are also concerned with the expansion of their coverage, but to a less extent with the problem of continuity, since their operations usually extend over all provinces and since benefits under their policies, with the exception of maternity benefits, do not normally depend on length of membership.

Wider coverage is sought in order to spread the insurance risks over as broad a base as possible. For this same reason emphasis has been placed on enrollment of members in groups rather than as individuals. Roughly 80 per cent of the enrolled population are covered under employed group contracts. The degree of success that these voluntary programs have had in enrolling the Canadian population is indicated in Table 7, which shows that the non-profit plans

have increased their coverage from 9 to 16 per cent of the population since 1950, and the private insurance companies have expanded coverage under their surgical contracts from 11 per cent of the population in 1950 to almost 18 per cent in 1953.

Table 7. PERCENTAGE OF TOTAL POPULATION ENROLLED UNDER NON-PROFIT AND PRIVATE INSURANCE SURGICAL AND MEDICAL CONTRACTS,(a) DECEMBER, 1950 TO 1953

Type of Contract	1950	1951	1952	1953
Non-Profit Plans				
Medical benefits(b)	9.1	11.2	13.6	15.7
Private insurance companies				
Surgical benefits	11.4	14.4	16.3	17.6
Medical benefits	4.8	6.7	8.8	9.6

(a) No attempt has been made to reduce these percentages to allow for duplication of coverage between non-profit and private insurance programs, or between group and individual contracts.

(b) Including Surgical Care.

Source: Data provided by individual non-profit plans, on the Joint Committee on Health Insurance.

Although the problem of providing continuous coverage for persons migrating between provinces is a relatively small one, it is exceedingly important to the persons concerned. Most of the non-profit plans have for some time arranged to continue the membership of persons who leave covered employment within the province under "group conversion" or "direct payment" contracts. Also, arrangements have recently been

completed whereby members can be covered, without loss of benefits, by a plan in another province to which they have migrated. This has been made possible by the Inter-Plan Transfer Agreement arranged by Trans-Canada Medical Plans.

Trans-Canada Medical Plans is a nation-wide association of non-profit medically-sponsored or endorsed plans established to co-ordinate their activities, to act as a clearing agency for information, and to promote the expansion of the plans. In addition to the Inter-Plan Transfer Agreement, this body has negotiated a standard Surgical, Obstetrical, and In-Hospital Medical Care contract for national employers who may enroll their employees in any province for the same benefits with the member plan in that province. The private insurance companies can offer nation-wide contracts without any such central co-ordination.

In order to increase their membership, many of the voluntary programs attempt to reduce the costs of insurance to their members by persuading employers to pay a portion of the premium on behalf of their employees. The Medical Services Association plan in British Columbia recommends to employers that the plan cannot be successfully introduced unless the employer pays 50 per cent of premiums, and most of the other non-profit and private insurance company plans encourage employer premium-sharing. Preliminary information from a survey of sickness benefit plans in manufacturing

establishments, conducted by the Department of Labour in April 1953, indicates that such premium-sharing has become quite extensive, as Tables 8 and 9 reveal. In this survey, 6470 manufacturing establishments with 983,700 employees returned questionnaires. Of these, 1917 reported that they had a comprehensive medical care benefit program for their 453,300 employees, and 1821 reported a limited medical care benefit program for their 362,900 employees. About 78 and 71 per cent of these employees, respectively, were actually insured.

At least two-thirds of all workers insured for comprehensive medical benefits were assisted by their employers to the extent of 50 per cent or more of their premium rates, including about 75 per cent of those insured under non-profit plans, and 70 per cent of those under private insurance companies. Among those workers insured for limited medical benefits, assistance amounting to 50 per cent or more of their monthly premiums was received by approximately 65 per cent of the covered employees of firms which chose to insure with private insurance companies, as compared with around 48 per cent of the covered employees of firms insured with non-profit plans; at least 57 per cent of all the workers insured for limited benefits received such assistance.

Table 8. PERCENTAGE DISTRIBUTION OF MANUFACTURING ESTABLISHMENTS AND EMPLOYEES INSURED FOR COMPREHENSIVE MEDICAL CARE BENEFITS, UNDER NON-PROFIT PLANS AND PRIVATE INSURANCE COMPANIES, BY EXTENT OF PREMIUM SHARING APRIL, 1953

Percentage of Premium Paid by Employer	Non-Profit Plans(a)		Private Insurance Companies(b)		All Underwriters (c)	
	Establishments	Insured Employees	Establishments	Insured Employees	Establishments	Insured Employees
0 per cent	18.8	10.5	15.0	6.1	11.7	10.4
1 to 24 " "	1.0	0.5	1.3	2.2	1.1	1.4
25 " "	2.4	1.7	2.6	7.0	2.5	4.4
26 to 49 " "	7.9	5.8	6.9	6.3	7.1	5.2
50 " "	47.5	55.7	45.8	50.8	48.3	40.9
51 to 74 " "	5.5	3.8	11.9	8.9	10.0	11.1
75 " "	1.1	0.7	1.1	1.2	1.3	1.2
76 to 99 " "	0.2	-	0.6	0.4	0.6	0.3
100 " "	6.8	14.2	6.9	9.2	7.1	11.9
Unspecified	6.0	5.2	3.9	4.7	6.2	10.4
No Information	2.8	1.8	4.0	3.1	4.2	2.6
Total	100.0	100.0	100.0	100.0	100.0	100.0
Total Number(d)	91[illegible]	130,[illegible]36	1237	210,690	1917	355,742

(See next page for footnotes)

(a) These figures include all establishments which have contracts with non-profit plans, some of which also have contracts with private insurance companies.

(b) These figures include all establishments which have contracts with private insurance companies, some of which also have contracts with non-profit plans.

(c) These figures include all establishments which have comprehensive medical care benefit programs, including those operated by employers and unions.

(d) The 1917 manufacturing establishments which reported a comprehensive medical care benefit program for their employees represented 30 per cent of the 6470 manufacturing establishments in the survey. Insured workers in these establishments represented 78 per cent of their 453,271 employees, or 36 per cent of the 983,700 employees covered by the survey.

Source: Research Division, Department of National Health and Welfare, preliminary tabulations of data from the Department of Labour's Survey of Working Conditions, April, 1953. Subject to revision.

Table 9. PERCENTAGE DISTRIBUTION OF MANUFACTURING ESTABLISHMENTS AND EMPLOYEES INSURED FOR LIMITED MEDICAL CARE BENEFITS, UNDER NON-PROFIT PLANS AND PRIVATE INSURANCE COMPANIES, BY EXTENT OF PREMIUM SHARING, APRIL, 1953

Percentage of Premium Paid by Employer	Non-Profit(a) Plans		Private Insurance(b) Companies		All Underwriters(c)	
	Esta-blishments	Insured Employees	Esta-blishments	Insured Employees	Esta-blishments	Insured Employees
0 per cent	36.4	27.3	6.9	4.7	19.4	12.7
1 to 24 " "	2.6	2.0	2.0	2.2	2.2	1.7
25 " "	1.2	0.6	1.7	1.0	1.7	1.0
26 to 49 " "	7.4	10.0	10.2	9.0	8.7	8.3
50 " "	27.8	25.6	45.2	36.6	37.7	31.2
51 to 74 " "	4.9	10.5	13.2	12.1	9.9	11.6
75 " "	1.3	1.1	1.4	0.8	1.3	0.7
76 to 99 " "	0.2	0.2	1.0	0.7	0.8	0.6
100 " "	6.9	10.2	8.8	14.7	8.2	12.4
Unspecified	7.4	9.5	5.7	14.9	6.2	13.3
No Information	3.9	2.9	3.9	3.2	3.9	6.4
Total	100.0	100.0	100.0	100.0	100.0	100.0
Total Number(d)	814	89,029	1100	168,025	1821	257,362

(See next page for footnotes.)

(a) These figures include all establishments which have contracts with non-profit plans, some of which also have contracts with private insurance companies.

(b) These figures include all establishments which have contracts with private insurance companies, some of which also have contracts with non-profit plans.

(c) These figures include all establishments which have limited medical care benefit programs, including those operated by employers and unions.

(d) The 1821 manufacturing establishments which reported a limited medical care benefit program for their employees represented 28 per cent of the 6470 manufacturing establishments in the survey. Insured workers in these establishments represented 71 per cent of their 362,853 employees, or 26 per cent of the 983,700 employees covered by the survey.

Source: Research Division, Department of National Health and Welfare, preliminary tabulations of data from the Department of Labour's Survey of Working Conditions, April, 1953. Subject to revision.

It is of interest to note that a larger percentage of the workers insured for limited benefits with private insurance companies had their full premium paid by their employers (15 per cent) than those insured for such benefits with non-profit plans (10 per cent). On the other hand, the non-profit plans had enrolled a greater proportion (14 per cent) of the workers insured for comprehensive benefits under contracts for which the employers paid the full premium, than had the private insurance companies (9 per cent). It is more frequently the larger establishments which pay 100 per cent of the premium costs for their employees, since although 12 per cent of all the workers insured for either comprehensive or limited benefits had their full premiums paid by their employers, they were employed by only 7 or 8 per cent of the establishments. This fact is even more striking when the comprehensive contracts with non-profit plans are considered alone; here over 14 per cent of the insured workers are employed by less than 7 per cent of the firms with such contracts, each of which pays 100 per cent of employees' premiums.

Since at least 62 per cent of all the workers in the survey who were insured for some type of medical care benefits were relieved by their employers from paying 50 per cent or more of their premiums, it is evident that employer sharing of premiums is now an important feature of financing medical care insurance in Canada.

CHAPTER III - HOSPITAL CARE INSURANCE

COVERAGE AND BENEFITS

The voluntary hospital care insurance plans have adopted two general approaches to the provision of hospital benefits which might be termed the "service" approach and the "indemnification" or "reimbursement"(1) approach. "Service" contracts entitle members to a maximum number of days of hospital care annually, without charge to the patient, together with certain special services, towards the cost of which the patient may be asked to contribute. "Indemnification" and "reimbursement" contracts emphasize the cash payments that the plans will make towards the hospital costs incurred by insured persons, who are responsible for any difference between these sums and the regular hospital charges.

The definition of a hospital "service" contract is not as precise as that of the "service" contracts providing medical care benefits. Members may purchase a contract covering the full hospital charges for room and board and routine nursing services, the use of operating and delivery rooms, laboratory and diagnostic services, anaesthesia supplies, dressings and plaster casts, and emergency out-patient care, and part of the charges for special services such as x-rays and drugs. Furthermore, some of the service plans have introduced what might be called a "co-insurance factor"

---

(1) See p. 8.

whereby the patient is required to pay a certain portion of his own bill. The indemnification and reimbursement contracts set fixed maximum sums which will be paid to help cover the costs of specified auxiliary services such as the use of the operating room, anaesthesia supplies, and laboratory and diagnostic services, in addition to the fixed maximum daily amounts which will be paid the patient (or the hospital) toward the costs of basic services such as room and board and routine nursing care.

The distinction between the concepts of "co-insurance" under a service contract and "indemnification" or "re-imbursement" should be noted. Under the former the actual amount, or proportion of the total bill, to be paid by the patient is set forth in his contract; the remaining charges are met by the plan as specified in the contract. Under indemnification and reimbursement contracts, the maximum amount the plan will be liable for is set forth in the contract; the remaining costs, if any, are met by the patient.

Service contracts are written by five of the eight non-profit plans offering hospital care benefits, including two which also write indemnification contracts. Altogether, indemnification contracts are written by five non-profit plans. The great majority of the hospital benefit contracts written by private insurance companies are of the reimbursement type.

(1) Non-profit Plans

(a) Types of Contract

The "Comprehensive Contract" offered by the Ontario Blue Cross plan is the only contract which agrees to meet the patient's entire bill for all necessary hospital services,(1) although the service contracts written by the five Blue Cross plans in Canada all agree to pay the full charges to the patient for room and board and routine nursing for a specified maximum number of days. Three of these plans in 1953, however, set maximum payments of from $10 to $25 per admission for all drugs, and the other two set similar maxima on the amounts they would pay for special drugs. In addition, three of the plans set limits of $10 to $25 on the amounts they would pay for x-ray services, and three limited their liability in maternity cases to 50 per cent of the costs, or $75 to $80 per case. The Blue Cross plans in Manitoba, Ontario and the Maritimes have in recent years introduced contracts which contain a co-insurance factor requiring the patient to pay, for example, the first $15 or $25 incurred, thus counterbalancing to some extent the liability that the plans assume in agreeing to pay the full cost of room and board. It should also be pointed out that most service plans offer their subscribers a choice between contracts providing semi-private or standard ward care. Subscribers, of course, may take more expensive accommodation and pay the difference themselves.

(1) Restricted only as to duration of stay - a maximum of 120 days per admission is allowed.

The maximum daily rates for hospital room and board allowed under non-profit indemnification contracts in 1954 varied from $1 in the Alberta Blue Cross plan(1) to $7 in the Quebec Blue Cross plan. The Associated Medical Services plan in Ontario (an independent non-profit scheme) allowed $9 per day to cover all hospital services. The other four indemnification plans allowed maxima per admission of $10 to $17.50 for drugs, $15 to $25 for x-rays, $20 to $25 for laboratory and diagnostic services, and $4 to $7 per day in maternity cases. All service and indemnification contracts offered by non-profit plans limit the number of days per year or per admission for which they assume responsibility, varying from 31 to 210 days per year, or from 21 to 120 days per admission.

Five of the eight non-profit hospital care plans will enroll individual members who are not eligible to enroll in employed groups; such non-group contracts are available in every province except Quebec.(2) In addition, four plans will enroll members of credit unions or co-operatives, or residents of communities, on a group basis. Figures are not at present available to show the proportion of total enrollment covered under such contracts. Usually contracts for

(1) In Alberta, persons covered under the Municipal Hospital Plan are charged a maximum of $1 per day for public ward room and board.

(2) Excluding also B.C. and Saskatchewan, where public programs are in operation.

non-group subscribers exclude treatment for pre-existing conditions from the benefits they provide, or impose a twelve-month waiting period before such treatment is available. Similarly, waiting-periods of greater length than those under group contracts are required before non-group subscribers can claim hospital benefits for confinements, and for tonsillectomies, herniotomies, and certain other elective operations. The Manitoba and Maritime Blue Cross plans require their non-group subscribers to pay a portion of their own bills - $15 under the former, and 25 per cent up to $100 under the latter plan.

(b) Coverage

Coverage under the non-profit plans increased from 2.7 million persons in December 1949 to 3.5 million at the end of 1953, an increase of about 30 per cent. The five Blue Cross plans accounted for 3.2 million persons, or 92 per cent of the 1953 total enrollment.(1) Enrollment under service contracts expanded from about 2 million persons in 1949 to about 3 million in 1953, as compared with a decline in indemnification contract enrollment over this period from 700,000 to about 500,000 insured persons.

About 23 per cent of the total Canadian population was covered for hospital insurance under the non-profit plans

(1) The remaining 8 per cent were enrolled under Associated Medical Services (Ont.), Cooperative Medical Services Federation (Ont.), and Les Services de Sante du Quebec.

in 1953; if the populations of British Columbia and Saskatchewan were excluded, however, this proportion would rise to 27 per cent. The provinces of Manitoba and Ontario had enrolled 41 per cent of their populations for such coverage, as shown in Table 10. Newfoundland and Alberta had the smallest proportion of population covered under non-profit plans - 2 per cent and 11 per cent respectively - but both these provinces have compulsory public hospital care programs in operation for many of their residents. Chart 2 further illustrates the proportion of the population covered in each province.

TABLE 10 NUMBERS OF PERSONS AND PERCENTAGES OF POPULATION ENROLLED FOR HOSPITAL CARE INSURANCE, UNDER NON-PROFIT PLANS AND PRIVATE INSURANCE COMPANIES,(a) BY PROVINCE, DECEMBER 1953.

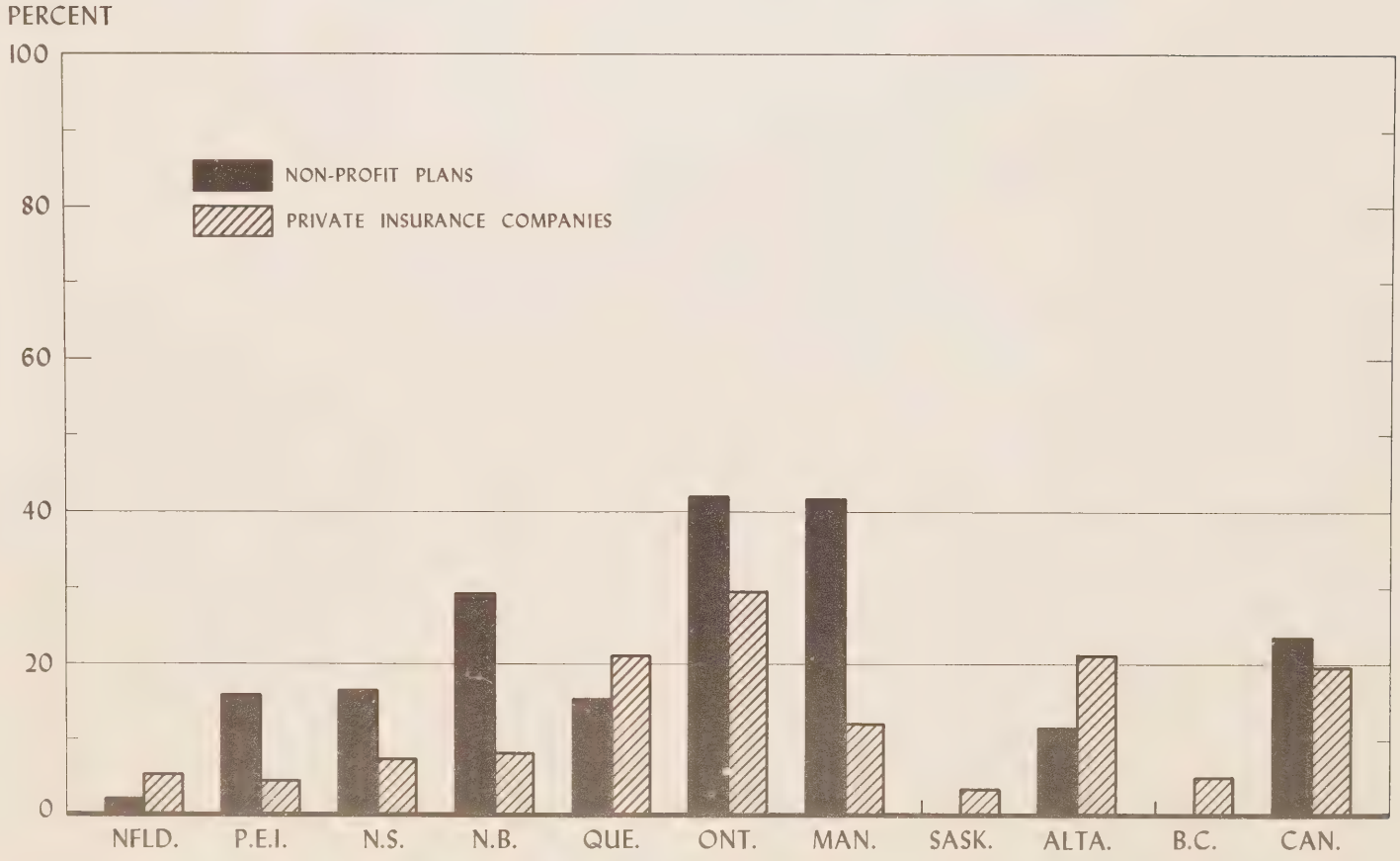
Province	Non-Profit Plans Enrollment		Private Insurance Co's,(b) Enrollment	
	Total	Percent of Population	Total	Percent of Population
Nfld.	8,068	2.1	22,200	5.7
P.E.I.	16,814	15.9	4,600	4.4
N. S.	108,435	16.2	51,000	7.6
N. B.	156,737	28.9	44,400	8.2
Que.	655,928	15.2	913,000	21.1
Ont.	2,056,047	41.4	1,471,800	29.6
Man.	338,181	41.3	99,000	12.1
Sask.	-	-	30,800	3.5
Alta.	115,000	11.3	215,300	21.1
B. C.	-	-	61,800	5.0
CAN.(c)	3,455,210	23.1	2,913,900	19.5

(a) These figures should not be added horizontally, since no allowance has been made for duplication in enrollment under non-profit plans and private insurance companies.
(b) No allowance made for duplication of coverage under group and individual contracts.
(c) Excluding Yukon and N.W.T.

Source: Based on data provided by each of the non-profit plans, and by the Joint Committee on Health Insurance.

CHART 2

PERCENTAGES OF TOTAL POPULATION[a] ENROLLED FOR HOSPITAL CARE BENEFITS, UNDER NON-PROFIT PLANS AND PRIVATE INSURANCE COMPANIES,[b] BY PROVINCE, DECEMBER 1953



[a] It should be noted that the provinces of B.C., Alta., Sask. and Nfld. operate public hospital programs

[b] Percentages should not be added, since no allowance has been made for duplication of coverage

Source: Table 10

In terms of the annual rates of growth of membership in these non-profit plans, there has been a considerable decline over the last eight years, as indicated in Table 11. Enrollment, which in 1946 was expanding at the rate of 37 per cent a year, and in 1947-48 at 23 to 24 per cent a year, in 1952 and 1953 increased by only 4 and 6 per cent, respectively, approximately double the annual 2 to 3 per cent increase in population.(1) This declining rate of growth, however, was experienced at a time when, under private or public auspices, about 60 per cent(2) of Canadians had purchased, or were otherwise covered for, some type of insurance against hospital bills. Moreover, there is some evidence that, among the subscribers to voluntary hospital insurance, the proportion of persons in the lower income groups is relatively small.(3)

---

(1) Contrast these rates with those relating to medical care in Table 1.

(2) See P. 46.

(3) The Canadian Sickness Survey conducted in 1951 indicated that 28 per cent of the families in the under $1500 income group, 55 per cent in the $1500-$3000 group, 67 per cent in the $3000-$5000 group, and 64 per cent in the over $5000 group had purchased some form of health care insurance in 1951, including both hospital and medical care insurance. (See Special Compilation No. 2.) Included in these figures are families covered under the public plans in British Columbia, Alberta, Saskatchewan and Newfoundland. A family was counted as having some type of insurance if only one member of the family had purchased insurance.

TABLE 11 PERCENTAGE INCREASE IN ENROLLMENT OVER PREVIOUS YEAR UNDER NON-PROFIT HOSPITAL PLANS, 1946 TO 1953

1946	1947	1948	1949	1950	1951	1952	1953
36.7	23.0	23.9	9.9	9.6	7.6	4.0	5.8

Source: Based on data provided by individual non-profit plans.

(c) National Organization

Like the medical care plans, five of the hospital care plans have formed a co-ordinating body known as the Canadian Council of Blue Cross Plans. In addition to acting as a clearing agency for information, this Council has made arrangements to facilitate the transfer of members from one plan to another, and to offer a standard contract for national employers with employees in several provinces.

(2) Private Insurance Company Plans

As in the case of medical care insurance contracts, coverage under hospital insurance contracts written by 38 private insurance companies has expanded very rapidly in the last few years - by 1 million persons, or over 50 per cent, between 1950 and 1953. Contracts covering 2.9 million persons for hospital benefits, or almost 20 per cent of the total Canadian population, were in force at the end of 1953, as shown in Table 10. As previously noted, these contracts were mainly of the "reimbursement" type: patients were reimbursed for their hospital costs up to fixed maximum daily rates for room, board and routine nursing,

together with additional sums - frequently amounting to ten times the daily rate for room and board - to be applied to the costs of the extra hospital services they received. In obstetrical cases a lump sum amount rather than a per diem rate, was commonly fixed as the maximum benefit payable.

The private insurance companies also write "limited reimbursement" contracts which limit the duration of hospital benefits regardless of the charge made by the hospital. For example, if a contract agreed to pay up to $8.00 per day for 60 days' hospitalization (that is, a maximum of $480), and an insured patient occupied a $6.00 per day room, under the ordinary "reimbursement" contract he would be reimbursed at the rate of $6.00 a day for a maximum of 80 days' continuous hospitalization until the $480 maximum was exhausted, but under the "limited reimbursement" contract he would be paid for no more than 60 days of continuous hospitalization, that is, up to a maximum of $360. Except for chronic or long-term cases, this limitation is not very significant.(1) Ordinary reimbursement policies are much more usual in Canada than the limited reimbursement or indemnity contracts.

Hospital expense contracts may be purchased on either a group or an individual basis. Individual contracts

---

(1) Although information regarding the length of stay of patients covered under the voluntary plans is not available, the experience of the Saskatchewan Hospital Service Plan indicates that almost 99 per cent of all cases in general and special hospitals are discharged within 60 days.

are extremely flexible because benefits can be designed to fit an individual's ability to purchase. For group contracts, the scope of benefits to be included can also be varied widely, depending on the extent of employer-employee financial participation desired. In 1953, 2.1 million persons were covered under group contracts as compared with 1.3 million at the end of 1950. Individual contracts covered 834,000 and 642,000 persons in these two years respectively. With no allowance for duplication in enrollment under both group and individual contracts, a total of about 2.9 million persons were covered under private insurance company hospital contracts in 1953, an increase of 51 per cent over the 1950 estimated enrollment of about 1.9 million persons. The provincial distribution of enrollment under these contracts is given in Table 10, where it will be noted that, despite the existence of a public program, Alberta had the second highest proportion of population covered under private insurance companies for hospital benefits[1] - 21 per cent - as compared with Ontario's 30 per cent enrollment.

---

(1) Since persons covered under the Alberta Municipal Hospital Scheme are required to pay $1 per day for public ward room and board, and either an additional $1 per day or the full cost of special hospital services, they may supplement their coverage under the public scheme by insuring against these costs, and the costs of more expensive accommodation, with one of the voluntary plans operating in the province. Non-ratepayers, of course, may prefer to purchase voluntary insurance rather than enroll under the Municipal Hospital program.

The annual rates of growth of coverage under private insurance company hospital contracts have, however, declined over this period.(1) Enrollment under group contracts increased by 29 per cent in 1951, by 14 per cent in 1952 and by only 11 per cent in 1953. Individual contract coverage, which had expanded considerably in 1952, remained almost unchanged at the end of 1953 owing to the discontinuation of individual contracts by one large company. A comparison with Table 11, however, shows that the private insurance companies are still expanding their coverage at a much more rapid rate than are the non-profit plans, although, as will be noted from Tables 13 and 14, they are paying only about two-thirds as much per member in benefits - due largely to the fact that the scope of benefits under insurance company contracts can be varied according to the amount the purchaser is willing to pay in premiums.

(3) Total Coverage of Non-profit and Private Companies

In summary, a total of 5.9 million persons, or 40 per cent of the total Canadian population, were covered under the voluntary plans for some type of hospital care benefits in 1953. This figure includes 3.5 million persons enrolled with the non-profit hospital care plans, and about 2.9 million persons insured with private insurance companies, with an allowance of 485,000 for duplication in enrollment under both group and individual contracts, and

(1) Compare with Table 3.

with both non-profit plans and private insurance companies. If the 2.8 million persons covered under four public hospital insurance programs were added to this figure, the total Canadian coverage for some type of hospital insurance in 1953 would be 8.7 million persons, or almost 60 per cent of our population. However, the number of members covered under any type of insurance must be related to the extent of protection received, such as the nature of the benefits available, the per capita payments on behalf of members, and the proportion of the patient's total bill met by his insurance. These factors must also be considered in estimating the effectiveness of an insurance program.

VOLUME OF SERVICE

National statistics are not available on the utilization experience of the five Blue Cross hospital care plans in Canada, but certain service statistics are available from the Annual Reports of four of the plans,(1) which together accounted for 40 per cent of the total membership of the eight non-profit plans in 1953. From these figures, which are given in Table 12, it can be seen that 12 to 15 per cent of the members of these plans are hospitalized each year. Over the period 1950 to 1954 the admission (discharge) rates of Plan A have varied from 140 to 150 per thousand beneficiaries, and of Plan B from 126 to 144 per thousand.

(1) Data from the Ontario Blue Cross Plan, which had enrolled 53 per cent of the total non-profit plan membership in 1953, were not available for this publication.

These are the two largest of the four reporting plans. The rates for Plans C and D were 168 and 158 per thousand beneficiaries in 1953, but these rates include out-patient and emergency cases. If such cases were excluded, it has been estimated that the rates for in-patient cases would be about 145 and 130 per thousand in Plans C and D, respectively. It should be noted, of course, that these are not only "new" admissions, but include the re-admissions of patients who have been in hospital previously during the year.

The average length of stay in hospitals under these plans in 1954 was between 8 and 10 days per case, as shown in Table 12. The average number of days of care per 1,000 beneficiaries ranged from 1,167 to 1,365 days. Changes in these rates between 1950 and 1954 are also indicated. At the present time information is not available regarding the relative volume of care received by persons under "service" and "indemnification" contracts, nor the utilization experience of private insurance companies offering contracts in this field.

FINANCIAL EXPERIENCE

In the post-war period there has been a very striking increase in the per diem costs of operating hospitals in Canada.(1) This increase has, however, not been uniform

(1) The per diem cost of operating public hospitals (excluding chronic hospitals) increased by about 140 per cent between 1945 and 1953.

TABLE 12 NUMBER OF CASES AND NUMBER OF DAYS IN HOSPITAL PER THOUSAND BENEFICIARIES, AND AVERAGE LENGTH OF STAY PER CASE, FOUR BLUE CROSS HOSPITAL CARE PLANS, 1950 TO 1954.[a]

Plan	1950	1951	1952	1953	1954
Plan A					
No. of Cases Per 1000 Members	139.8	145.4	149.5	145.7	145.3
Days of Care Per 1000 Members	1,109.0	1,137.1	1,163.1	1,137.5	1,167.3
Days of Stay Per Case	7.9	7.8	7.8	7.8	8.0
Plan B					
No. of Discharges Per 1000 Members	126	130	137	144	138
Days of Care Per 1000 Members	(b)	(b)	1,220	1,340	1,365
Days of Stay Per Case	9.4	9.2	9.2	9.5	10.0
Plan C[c]					
No. of Paid Cases Per 1000 Members	160	163	169	168	170
Days of Care Per 1000 Members	1,270	1,310	1,340	1,266	1,308
Days of Stay Per Case	8.0	8.1	7.9	7.5	7.7
Plan D[d]					
No. of Paid Cases Per 1000[e] Members	(b)	(b)	140	158	(b)
Days of Care Per 1000 Members	(b)	(b)	943	950	(b)
Days of Stay Per Case	(b)	(b)	7.7	7.4	(b)

(see next page for footnotes)

(a) Excluding out-patient and emergency cases, unless otherwise stated. Rates based on number of paid cases for each year.
(b) Information not available in Annual Reports.
(c) All rates include out-patient and emergency cases, as well as in-patients. If 90 percent of all cases in 1954 were in-patient cases, it is estimated that the rates for these cases would be 153 per 1000, 1290 days per 1000, and 8.4 days per case. If only 85 percent were in-patient cases, the rates for in-patients would be 145 cases per 1000, 1280 days per 1000, and 8.9 days per case.
(d) Year ended September 30.
(e) Including out-patients. If these were excluded, it is estimated that these rates would fall to 123 and 128 per thousand beneficiaries.

Source: Calculated from data contained in the Annual Reports of each of the Blue Cross plans concerned.

throughout the country so that there are rather widely divergent costs prevailing in different regions.(1) As a result of these cost increases, the service plans which contract to pay the full cost of room and board on behalf of their members have increased their payments to hospitals as the per diem rates have increased. The indemnification or reimbursement plans, on the other hand, are not so immediately concerned with increased per diem costs of hospital care, since they have contracted to pay only up to a fixed sum per day in benefits, regardless of the level of hospital charges to the patient.

(1) Non-profit Plans

Payments to hospitals for care received by members of the non-profit plans increased from almost $19 million in 1949 to almost $40 million in 1953, as indicated in Table 13, or from $7.45 to $11.80 per insured person.

Plans in Ontario and Quebec made payments of 60 per cent and 20 per cent of the total payments of all plans, percentages which roughly correspond to their membership. Ontario and Quebec also ranked highest in per capita terms, spending averages of $12.35 and $12.05 per beneficiary respectively. Alberta, with about 75 per cent of its population covered under the Municipal Hospital Scheme,

(1) In 1953, the per diem costs (excluding newborn days) of operating public general hospitals ranged from $8.88 in P.E.I. to $15.63 in B.C.

ranked lowest at $9.45 per capita. The greatest expansion in payments between 1949 and 1953 occurred in Ontario, where expenditures rose by 63 per cent from $7.60 to $12.35 per capita.

Although only limited information is available regarding the proportion of the patient's hospital bill that the non-profit plans are meeting, it is of interest to note that the Blue Cross plan in Manitoba reported that in 1954 it covered about 84 percent of the in-patient hospital bills incurred by its members. This percentage varied from 75 per cent for members holding Community contracts to 87 per cent for members with Semi-Private Room contracts. Included in the portion of the bills not covered by Blue Cross are the additional charges for more expensive accommodation than the members have contracted for, as well as certain special services not covered by the contracts, and the $15 or $25 deductible payments made directly to the hospitals by subscribers.

When payments for benefits are allocated according to the different types of services provided, information from one plan indicates that about 65 per cent of the total was paid for room and board and routine nursing services. The use of the operating and delivery rooms absorbed an additional 11 per cent, and about 9 per cent went for drugs, dressings, and emergency treatment. Laboratory, x-rays, and other diagnostic services accounted for the remaining 15 per cent of total benefit payments.

TABLE 13 AVERAGE NUMBER OF PERSONS COVERED FOR HOSPITAL BENEFITS UNDER EIGHT NON-PROFIT PLANS, AND TOTAL AND PER CAPITA EXPENDITURES ON BENEFITS, BY PROVINCE, 1949 AND 1953.

Province	1949			1953		
	Average No. of Persons Covered	Expenditures		Average No. of Persons Covered	Expenditures (a)	
		Total	Per Capita		Total	Per Capita
		$	$		$	$
Alta.	74,000	480,000(b)	7.05(c)	114,000	1,080,000	9.45
Man.	272,000	2,100,000	7.70	334,000	3,347,000	10.00
Ont.	1,386,000	10,511,000	7.60	1,964,000	24,273,000	12.35
Que.	474,000	3,586,000	7.55	668,000	8,049,000	12.05
Atlantic Provinces	293,000	2,007,000	6.85	290,000	3,009,000	10.35
Canada	2,500,000	18,684,000	7.45	3,370,000	39,756,000	11.80

(a) See Appendix II.
(b) For a period of 11 months.
(c) Monthly average times 12 to obtain an annual average.

Source: Information provided by the non-profit plans concerned.

The costs of administering hospital care benefits amounted to $3.5 million for all the non-profit plans in 1953, or 8.7 per cent of their income during that year.(1) On a provincial basis, administration costs ranged from a low of 7.3 per cent of income in the Maritimes to 9.3 per cent in Manitoba. Reserves accumulated by these plans during the year amounted to $1.1 million, or about 2.6 per cent of total income. In other words, after allowing for administration and reserves, the non-profit plans returned about 89 cents out of every dollar received by the plans in the form of hospital care benefits to their members in 1953.

(2) Private Insurance Company Plans

Insured patients were reimbursed for their hospital expenses by the private insurance companies to a total of almost $23 million in 1953, as shown in Table 14, amounting to an average of about $8.15 per insured person. Over half this amount was distributed to residents of Ontario, and almost one-third to Quebec. This represents a very considerable increase over the estimated $9 or $10 million paid out by insurance companies in 1950.

On a per capita basis, residents of the five eastern provinces received more than the national average, while residents of the five western provinces received less. This is understandable when it is recalled that three of the western provinces have public hospital plans covering the majority of their residents.

(1) See Appendix II.

TABLE 14 AVERAGE NUMBER OF PERSONS COVERED FOR HOSPITAL BENEFITS UNDER 38 PRIVATE INSURANCE COMPANIES, AND TOTAL AND PER CAPITA EXPENDITURES ON BENEFITS, BY PROVINCE, 1953

Province	Average No. of Persons Covered(a)	Expenditures	
		Total	Per Capita (b)
		$	$
Newfoundland	19,000	164,000	8.70
P.E.I.	4,000	40,000	9.75(c)
Nova Scotia	48,000	500,000	10.35(c)
New Brunswick	41,000	355,000	8.75
Quebec	839,000	7,309,000	8.70
Ontario	1,492,000	11,835,000	7.95
Manitoba	97,000	691,000	7.15
Saskatchewan	24,000	176,000	7.30
Alberta	193,000	1,491,000	7.75
British Columbia	52,000	359,000	6.85
Canada	2,809,000	22,920,000	8.15

(a) Based on coverage at beginning and end of year.
(b) These figures were calculated before average enrollment figures were rounded.
(c) These figures are probably high, since they are based on very rough estimates of total expenditures.

Source: Data provided by the Joint Committee on Health Insurance.

(3) Employer Participation in Premium Payments

As in the case of the medical care plans, many of the voluntary hospital care plans encourage employers to meet a portion of their employees' premiums. The Survey of Sickness Benefit Plans in manufacturing establishments, which was mentioned previously,(1) revealed the extent to which this practice of sharing premiums had become established in 1953. As Table 15 indicates, at least(2) 60 per cent of

(1) See page 29.
(2) For almost 15 percent of the insured employees, information regarding premium sharing was either not provided, or not given in percentage terms.

the 700,000 employees insured for some type of hospital care benefits were assisted by employers who paid 50 per cent or more of their premium rates. These employers represented 53 per cent of the 4,522 employers having a hospital benefit program in operation in their establishments. About 8 per cent of the employers paid the full premium on behalf of their insured workers, who accounted for almost 13 per cent of all insured employees. On the other hand, about an equal proportion of the insured workers - 14 per cent - paid the full premium themselves.

When these hospital benefit programs are separated into those which were provided by non-profit plans and those underwritten by private insurance companies, a somewhat different pattern appears. Only about half of the workers insured under non-profit hospital programs were relieved of 50 per cent or more of their premiums. About 10 per cent were relieved of the full premium, while 28 per cent paid the whole premium themselves. However, among hospital insurance programs underwritten by private insurance companies, at least 69 per cent of the insured workers were assisted by their employers to the extent of 50 per cent or more of their premiums. The full premium was paid for 14 per cent of the insured workers by their employers; only 5 per cent of the workers paid the full premium themselves. The more extensive employer participation under private insurance company contracts is no doubt due in part to the

fact that such contracts generally form part of a "package" of benefits, along with indemnification for wage loss due to illness and life insurance, which is the subject of collective bargaining between employers and unions.

SUMMARY

Voluntary hospital insurance plans in Canada have expanded their membership from about 3.9 million persons in 1949 to 5.9 million persons in 1953, after adjusting for duplication, or from 29 to 40 per cent of total population. In all, about 60 per cent of the 1953 population were covered for some kind of hospital benefits under the voluntary plans and the four provincial hospital care programs. Over this same period, total expenditures on hospital benefits rose from an estimated $32 million in 1949 to $63 million in 1953. (See Tables 13 and 14). It is estimated that about $35 million was spent in 1953 under service contracts, all of which were written by non-profit plans, and $28 million was paid out under idemnification or reimbursement contracts.

Payments by voluntary hospital plans in 1953 are estimated to have represented about 40 per cent of payments to public and private hospitals excluding mental, tuberculosis, and federal hospitals, either by patients directly or on their behalf by the voluntary plans, or about 24 per cent of total payments to such hospitals from all sources.

TABLE 15 PERCENTAGE DISTRIBUTION OF MANUFACTURING ESTABLISHMENTS AND EMPLOYEES INSURED FOR HOSPITAL CARE BENEFITS, UNDER NON-PROFIT PLANS AND PRIVATE INSURANCE COMPANIES, BY EXTENT OF PREMIUM SHARING, APRIL, 1953.

Percentage of Premium Paid by Employer	Non-Profit Plans(a)		Private Insurance Companies(b)		All Underwriters(c)	
	Estab-lishments	Insured Employees	Estab-lishments	Insured Employees	Estab-lishments	Insured Employees
0 per cent	41.3	27.8	6.3	5.3	24.4	14.1
1 to 24 " "	1.9	1.8	2.0	2.9	1.8	2.2
25 " "	1.5	1.4	2.1	3.7	2.2	3.1
26 to 49 " "	6.2	7.2	9.2	7.5	7.1	6.7
50 " "	24.6	32.5	48.0	42.5	34.9	34.2
51 to 74 " "	4.6	6.0	13.4	10.9	8.9	11.3
75 " "	1.2	0.9	1.1	0.9	1.3	1.0
76 to 99 " "	0.4	0.1	0.7	0.5	0.6	0.3
100 " "	6.4	9.8	8.4	13.9	7.7	12.6
Unspecified	6.5	8.2	4.4	7.7	5.8	9.5
No Information	5.3	4.4	4.3	4.1	5.3	5.0
Total	100.0	100.0	100.0	100.0	100.0	100.0
Total Number (d)	2400	311,721	2280	437,195	4522	700,635

(a) These figures include all establishments which have contracts with non-profit plans, some of which also have contracts with private insurance companies. (b) These figures include all establishments which have contracts with private insurance companies, some of which also have contracts with non-profit plans. (c) These figures include all establishments which have hospital insurance programs, including those operated by employers and unions. (d) The 4522 manufacturing establishments which reported a hospital care benefit program for their employees represented 70 per cent of the 6470 manufacturing establishments in the survey. Insured workers in these establishments represented 81 per cent of their 866,500 employees, or 71 per cent of the 983,700 employees covered by the survey.

Source: Research Division Department of National Health and Welfare, preliminary tabulations of data from the Department of Labour's Survey of Working Conditions, April 1953. Subject to revision.

APPENDICES

APPENDIX I

REVENUES AND EXPENDITURES OF FOURTEEN NON-PROFIT MEDICAL CARE INSURANCE PLANS, AND ESTIMATED EXPENDITURES ON SURGICAL AND MEDICAL BENEFITS BY PRIVATE INSURANCE COMPANIES, BY PROVINCE, 1953

Province	Non-Profit Plans						Private Insurance Companies
	Revenues		Expenditures			Net Surplus on Operations	Estimated Expenditures on Surgical & Medical Benefits
	Premium Contributions	Total	Benefits	Administration	Total		
British Columbia[a]	5,591,000	5,610,000	4,891,000	315,000	5,206,000	404,000	602,000
Alberta[a]	1,048,000	1,052,000	877,000	124,000	1,001,000	51,000	921,000
Saskatchewan[a]	1,899,000	1,926,000	1,606,000	197,000	1,803,000	123,000	189,000
Manitoba	3,223,000	3,238,000	3,092,000	288,000	3,380,000	-142,000	419,000
Ontario	11,869,000	11,971,000	10,004,000	1,047,000	11,051,000	920,000	7,787,000
Quebec	5,187,000	5,220,000	4,629,000	432,000	5,061,000	159,000	4,755,000
New Brunswick	1,131,000	1,142,000	863,000	170,000	1,033,000	109,000	230,000
Nova Scotia	1,151,000	1,156,000	957,000	128,000	1,085,000	71,000	272,000
P.E.I.	104,000	105,000	80,000	15,000	95,000	10,000	29,000
Newfoundland	50,000	51,000	38,000	8,000	46,000	5,000	150,000
CANADA	31,253,000	31,471,000	27,037,000	2,724,000	29,761,000	1,710,000	15,354,000

(a) Fiscal Year ended closest to December 31, 1953.

APPENDIX II

REVENUES AND EXPENDITURES OF EIGHT NON-PROFIT HOSPITAL CARE INSURANCE PLANS, AND ESTIMATED EXPENDITURES ON HOSPITAL BENEFITS BY PRIVATE INSURANCE COMPANIES, BY PROVINCE, 1953

Province	Non-Profit Plans						Private Insurance Companies
	Revenues		Expenditures			Net Surplus on Operations	Estimated Expenditures on Hospital Benefits
	Premium Contributions	Total	Benefits	Administration	Total		
British Columbia	-	-	-	-	-	-	359,000
Alberta[a]	1,341,000	1,350,000	1,080,000	105,000	1,185,000	165,000	1,491,000
Saskatchewan	-	-	-	-	-	-	176,000
Manitoba	3,832,000	3,862,000	3,347,000	358,000	3,705,000	157,000	691,000
Ontario	26,195,000	26,510,000	24,273,000	1,995,000	26,268,000	242,000	11,835,000
Quebec	8,899,000	8,957,000	8,049,000	747,000	8,796,000	161,000	7,309,000
New Brunswick	1,990,000	1,997,000	1,623,000	146,000	1,769,000	228,000	355,000
Nova Scotia	1,330,000	1,335,000	1,085,000	98,000	1,183,000	152,000	500,000
P.E.I.	297,000	298,000	242,000	22,000	264,000	34,000	40,000
Newfoundland	70,000	71,000	57,000	5,000	62,000	9,000	164,000
CANADA	43,954,000	44,380,000	39,756,000	3,476,000	43,232,000	1,148,000	22,920,000

(a) Fiscal year ending Sept. 30, 1953.

PUBLICATIONS IN THE SOCIAL SECURITY AND THE GENERAL SERIES

Research Division,
Department of National Health and Welfare

I. SOCIAL SECURITY SERIES

* Memorandum No. 1. Mothers' Allowances Legislation in Canada. 1st ed. May 1949, 2nd ed. January, 1955, pp.

* Memorandum No. 2. Old Age Income Security in New Zealand. March 1950. 41 pp.

* Memorandum No. 3. Old Age Income Security in Australia. March 1950. 31 pp.

_/ Memorandum No. 4. Old Age Income Security in Great Britain. March 1950. 84 pp.

_/ Memorandum No. 5. Old Age Income Security in the United States. March 1950. 76 pp.

_/ Memorandum No. 6. Old Age Income Security in Selected European Countries. (Denmark, France, Sweden, Switzerland). March 1950. 83 pp.

O Memorandum No. 7. Social Security in Australia.

* Memorandum No. 8. Health Insurance in New Zealand. October 1950. 88 pp.

* Memorandum No. 9. Health Insurance in Denmark. (Revised) March 1952. 67 pp.

* Memorandum No. 10. Health Insurance in Sweden. January 1952. 76 pp.

* Memorandum No. 11. Health Insurance in Great Britain, 191[illegible]-48. March 1952. 163 pp.

O Memorandum No. 12. Health Insurance in Norway. Est. 60 pp.

O Memorandum No. 13. Health Insurance in the Netherlands. Est. 65 pp.

* Memorandum No. 14. Government Expenditures and Related Data on Health and Social Welfare 1947 to 1953. 2nd ed. June 1955. 84 pp.

* Memorandum No. 15. Selected Public Hospital and Medical Care Plans in Canada. July 1955. pp.

II. GENERAL SERIES

_/ Memorandum No. 1. Survey of Dentists in Canada. 2nd ed., January 1949, 45 pp.

* Memorandum No. 2. Survey of Physicians in Canada. 3rd ed., Sept. 1948, 4th ed., Sept. 1949, 5th ed., June 1951, 6th ed. April 1955, 36 pp.

* Memorandum No. 3. Survey of Welfare Positions: Report April 1954. 182 pp. and appendices.

* Memorandum No. 4. Voluntary Medical Care Insurance: A Study of Non-Profit Plans in Canada, April 1954, 205 pp.

* Memorandum No. 5. A Study of the Functions and Activities of Head Nurses in a General Hospital. May 1954, 140 pp.

* Memorandum No. 6. Mental Health Services in Canada, July 1954, 207 pp.

* Memorandum No. 7. Changes and Developments in Child Welfare Services in Canada, 1949-1953. October 1954, 33 pp.

* Memorandum No. 8. Survey of Welfare Positions, Summary of Report. May 1955. 34 pp.

* Memorandum No. 9. Voluntary Medical and Hospital Insurance in Canada. August 1955. pp.

* Memorandum No. 10. Hospitals in Canada. September 1955. pp.

* Memorandum No. 11. Tuberculosis Services in Canada. July 1955. 65 pp.

* Memorandum No. 12. Health Care in Canada Expenditures And Sources of Revenue, 1953. August 1955, est. 25 pp.

III. OTHER PUBLICATIONS

Bulletins prepared in collaboration with other Divisions of the Department or other agencies.

* Survey of Nursing Personnel in Manitoba, October 1952, 59 pp.

* A Suggested Methodology for Fluoridation Surveys in Canada, July, 1952, 51 pp.

* Dental Effects of Water Fluoridation, 1954 Report, August 1954, 33 pp.

_/ Rehabilitation of Disabled Persons. Background Data for the National Conference on Rehabilitation, Toronto, Feb. 1 - 3, 1951, 135 pp.

* Social Security Expenditures in Australia, Canada, Great Britain, New Zealand and the United States 1949-50 - A Comparative Study, February, 1954, 42 pp.

Canadian Sickness Survey

V Special Compilation: No. 1. Family Expenditures for Health Services (National Estimates), May, 1953, 13 pp.

V Special Compilation: No. 2. Family Expenditures for Health Services by Income Groups (National Estimates), July, 1953, 13 pp.

V Special Compilation: No. 3. Family Expenditures for Health Services by Expenditure Group (National Estimates), September, 1953, 56 pp.

V Special Compilation: No. 4. Family Expenditures for Health Services (Regional Estimates), January, 1954, 23 pp.

V Special Compilation: No. 5. Volume of Sickness (National Estimates), April, 1954, 24 pp.

V Special Compilation: No. 6. Permanent Physical Disabilities (National Estimates), February, 1955, 15 pp.

V Special Compilation: No. 7. Incidence and Prevalence of Illness (National Estimates), April, 1955, 20 pp.

---

* Available on request. _/ Out of print. O In preparation.

V Available from Queen's Printer, 25 cents a copy.